MEDI-CAL UPDATE Part 2
Billing and Policy
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Outpatient Services • AIDS Waiver Program

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CMC Claim Submission for Medicare/Medi-Cal Crossover Billers

Medi-Cal can now receive electronic crossover claims directly from approved submitters via the ASC X12N 837 v. 4010A1 transaction. Submitters using the 837 format must include Medicare payment information on the detail/claim line level. Additionally, Medi-Cal can receive electronic crossover claims automatically from Mutual of Omaha and United Government Services Medicare Intermediaries for most Part B services billed to Part A intermediaries. This new provision primarily affects outpatient and dialysis providers who were previously required to bill these claims on paper. Providers of Part B services billed to Part A intermediaries other than Mutual of Omaha and United Government Services must continue to bill their claims directly to Medi-Cal either on paper or in the new HIPAA standard 837 electronic transaction until a new automatic crossover process is established with the Medicare Consolidated Coordination of Benefits Contractor sometime in 2006.

In order to comply with HIPAA electronic standards, providers billing crossover claims on paper for Part B services billed to Part A intermediaries will be required to attach the detail/claim line level *National Standard Intermediary Remittance Advice* (Medicare RA) to a *UB-92 Claim Form* and comply with revised billing instructions. Any claims received after October 24, 2005 that do not comply with the new billing and attachment requirements will be returned to providers for correction before processing.

Providers may obtain detailed Medicare RAs by printing the "Single Claim" report, which can be accessed through the latest version of PC Print software, available free of charge. PC Print software and instructions are available on the United Government Services Web site **(www.ugsmedicare.com)** by clicking "Providers," then "EDI" and then the "PC Print Software" link. Providers should obtain the PC Print software from Medicare as soon as possible to ensure they can print the appropriate Medicare RAs.

2006 ICD-9-CM Diagnosis Code Updates

The following diagnosis code additions, inactivations and revisions are effective for claims with dates of service on or after January 1, 2006. Providers may refer to the *2006 International Classification of Diseases, 9th Revision, Clinical Modifications, 6th Edition* for ICD-9 code descriptions.

Additions

259.50	276.50	276.51	276.52	278.02	287.30	287.31	287.32
287.33	287.39	291.82	292.85	327.00	327.01	327.02	327.09
327.10	327.11	327.12	327.13	327.14	327.15	327.19	327.20
327.21	327.22	327.23	327.24	327.25	327.26	327.27	327.29
327.30	327.31	327.32	327.33	327.34	327.35	327.36	327.37
327.39	327.40	327.41	327.42	327.43	327.44	327.49	327.51
327.52	327.53	327.59	327.8	362.03	362.04	362.05	362.06
362.07	426.82	443.82	525.40	525.41	525.42	525.43	525.44
525.50	525.51	525.52	525.53	525.54	567.21	567.22	567.23
567.29	567.31	567.38	567.39	567.81	567.82	567.89	585.1
585.2	585.3	585.4	585.5	585.6	585.9	599.60	599.69
651.70	651.71	651.73	760.77	760.78	763.84*	770.10*	770.11*
770.12*	770.13*	770.14*	770.15*	770.16*	770.17*	770.18*	770.85*
770.86*	779.84*	780.95	799.01	799.02	996.40	996.41	996.42
996.43	996.44	996.45	996.46	996.47	996.49	V12.42	V12.60
V12.61	V12.69	V13.02	V13.03	V15.88	V17.81	V17.89	V18.9
V26.31	V26.32	V26.33	V46.13	V46.14	V49.84	V58.11	V58.12
V59.70§	V59.71§**	V59.72§**	V59.73†§	V59.74†§	V62.84	V64.00	V64.01
V64.02	V64.03	V64.04	V64.05	V64.06	V64.07	V64.08	V64.09
V69.5	V72.42§	V72.86	V85.0††	V85.1††	V85.21††	V85.22††	V85.23††
V85.24††	V85.25††	V85.30††	V85.31††	V85.32††	V85.33††	V85.34††	V85.35††
V85.36††	V85.37††	V85.38††	V85.39††	V85.4††			

Restrictions

*	Restricted to ages 0 thru 1 year
**	Restricted to ages 10 thru 35 years
†	Restricted to ages 35 thru 55 years
††	Restricted to ages 18 thru 99 years
§	Restricted to females only

Inactive Codes

Effective for dates of service on or after January 1, 2006, the following ICD-9 diagnosis codes are no longer reimbursable:

276.5, 287.3, 567.2, 567.8, 585, 599.6, 770.1, 799.0, 996.4, V12.6, V17.8, V26.3, V58.1, V64.0

Code Description Revisions

The descriptions of the following ICD-9 diagnosis codes are revised:

285.21, 307.45, 403.00, 403.01, 403.10, 403.11, 403.90, 403.91, 404.00, 404.01, 404.02, 404.03, 404.10, 404.11, 404.12, 404.13, 404.90, 404.91, 404.92, 404.93, 728.87, 780.51, 780.52, 780.53, 780.54, 780.55, 780.57, 780.58

All manual replacement pages reflecting these ICD-9 code updates will be included in future *Medi-Cal Updates.*

Inpatient Provider Cutoff Date for Proprietary and Non-HIPAA Standard Electronic Claim Formats: December 1, 2005

In accordance with efforts to comply with the federally mandated Health Insurance Portability and Accountability Act (HIPAA), Medi-Cal is planning to discontinue acceptance of proprietary and non-HIPAA standard electronic formats for electronic claim transactions. The first provider community to be affected is the Inpatient provider community.

Beginning **December 1, 2005,** proprietary and non-HIPAA standard electronic claim formats submitted by Inpatient providers will no longer be accepted.

Self-Service HIPAA Transaction Utility Tool
A self-service environment, HIPAA Transaction Utility Tool, will soon be available for submitters. Initially, the utility tool will be available only for inpatient submitters to validate ASC X12N 837 v.4010A1 transactions in preparation for proprietary format discontinuance. However, the utility tool will become available to other submitter communities as their timeline for proprietary format discontinuance is determined.

The utility tool will offer transaction validation (inclusive of Companion Guide-level editing), troubleshooting and reporting features that enhance, but do not replace, Medi-Cal's current testing and media activation requirements. Inpatient submitters have been notified of the utility tool's availability via e-mail or letter depending on information availability.

Providers may call the Telephone Service Center (TSC) at 1-800-541-5555 for more information.

Cutoff dates for non-HIPAA standard claim formats for all other provider communities will be announced in upcoming *Medi-Cal Updates*.

Modifier Sections Updated in Provider Manual

Due to a consolidation of information regarding modifier policy, the Department of Health Services is removing the section *Modifiers for Outpatient Services* ("modif op") and adding the section *Modifiers* ("modif"). All Medi-Cal policy remains the same. All policy found in *Modifiers for Outpatient Services* is now in *Modifiers*.

Instructions for Manual Replacement Pages — Part 2

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Remove and replace:	*Contents for AIDS Waiver Program Billing and Policy i/ii* *****
Insert new section after *Medicare Non-Covered Services: HCPCS Codes* section:	modif 1 thru 3 *(new)*
Remove:	modif op 1/2

* Pages updated due to ongoing provider manual revisions.